



Alpine Dermatology Associates, P.L.L.C.

PATIENT QUESTIONNAIRE

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care operations): _____

2. Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**:

Name: _____ Phone: _____

Name: _____ Phone: _____

3. Please print the address of where you would like your postcards and/or correspondence from our office to be sent if other than your home: _____

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL." (Circle response)

YES NO

5. Please write the telephone number where you want to receive calls about your appointments, lab results, or other health care information if other than your home phone number*:

**I am fully aware that a cellular phone is not a secure and private line.*

6. Can confidential messages be left on your telephone answering machine? (Circle response)

YES NO

7. I am fully aware that my health information can be transmitted by electronic transmission, by fax transmittal, by Internet, or by e-mail.

PATIENT
SIGNATURE: _____ DATE: _____
(Guardian if under age 18 years)